Consumer Federation of America

STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

"CURRENT ISSUES RELATED TO MEDICAL LIABILITY REFORM"

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Executive Summary: Testimony of J. Robert Hunter
February 10, 2005

- The "hard" insurance market, which took hold shortly after September 11, 2001, and the insurance industry's own business practices are largely to blame for the rate shock that physicians have experienced in the last few years.
- Recent data shows that sharp medical malpractice insurance rate increases have ended. In 2004, medical malpractice premiums rose by just four percent. These rates are expected to level out for the next few years.
- The rate problem was caused by the classic turn in the economic cycle of the industry, sped up--but not caused by--terrorist attacks.
- Further limiting patients' rights to sue for medical injuries would have virtually no impact on lowering overall health care costs. Medical malpractice insurance costs as a proportion of national health care spending are miniscule, amounting to 60 cents per $100 spent.
- Insurer losses for medical malpractice have risen slowly in the last decade, by less than the rate of inflation.
- Malpractice claims have not "exploded" in the last decade. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2003. The average payment per closed claim over the last decade was $27,524, from which both the plaintiff and defense attorneys were compensated.
- As the worst of the malpractice insurance rate hikes are over, Congress has some time to conduct a thorough examination of the problem and to propose thoughtful solutions. Congress should not rush into changes to the medical liability system that would harm consumers and fail to address the insurance failures that are at the root of the problem.
- Congress should consider and act on insurance reform measures to control the harmful excesses of a business cycle that causes sudden and unjustifiable price spikes and coverage cutbacks every decade or so. Insurance reforms that should be considered include those modeled after California's Proposition 103 system and the creation of a national reinsurance facility.
- Congress should also assess and enact methods to reduce negligence and medical errors by physicians and medical facilities.
- Congress should also evaluate why so few people who are hurt by medical negligence receive any form of compensation and review no-fault and other mechanisms for addressing these problems.

Good morning. I am J. Robert Hunter, insurance director for the Consumer Federation of America. I am also an actuary, a former federal Insurance Administrator under Presidents Ford and Carter, and a former Texas Insurance Commissioner. CFA is a non-profit association of 300 organizations founded in 1968 to advance the consumer interest through research, advocacy and education.

I would like to thank Chairman Nathan Deal, Ranking Member Sherrod Brown and the other members of the Subcommittee for the opportunity to offer our comments on this extremely important issue. For the third time in less than thirty years, Congress and state legislators across the country have been grappling with the problem of fast-rising medical malpractice rates. Insurers insist that a sharp increase in large, unwarranted jury verdicts is to blame for the crisis. As a result, lawmakers on this Subcommittee and in a variety of states are considering legislation to place further limits on the legal rights of Americans who have been harmed or killed by medical malpractice.

However, my research over many years shows that insurers are pointing fingers when they should be looking in the mirror. I first studied this issue at the behest of President Ford when, in the mid-1970s, a hard market hit medical malpractice in much the same fashion as we are witnessing today. After doing research similar to what I will present to you today, the Ford White House decided not to push for tort reform since, as today, the sudden surge in prices for doctors was not due to a jump in claims, but was related to insurance industry economics.

It is the "hard" insurance market and the insurance industry's own business practices that are largely to blame for the rate shock that physicians have experienced in the last few years. Recent data also shows that sharp rate increases have ended (in 2004, medical malpractice premiums rose by just four percent) and are expected to level out for the next few years. CFA has also found that:

- The rate problem was caused by the classic turn in the economic cycle of the industry, sped up--but not caused by--terrorist attacks.
- Further limiting patients' rights to sue for medical injuries would have virtually no impact on lowering overall health care costs. Medical malpractice insurance costs as a proportion of national health care spending are miniscule, amounting to 60 cents per $100 spent.
- Insurer losses for medical malpractice have risen slowly in the last decade, by less than the rate of inflation.
- Malpractice claims have not "exploded" in the last decade. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2003. The average payment per closed claim over the last decade was $27,524, from which both the plaintiff and defense attorneys were compensated.

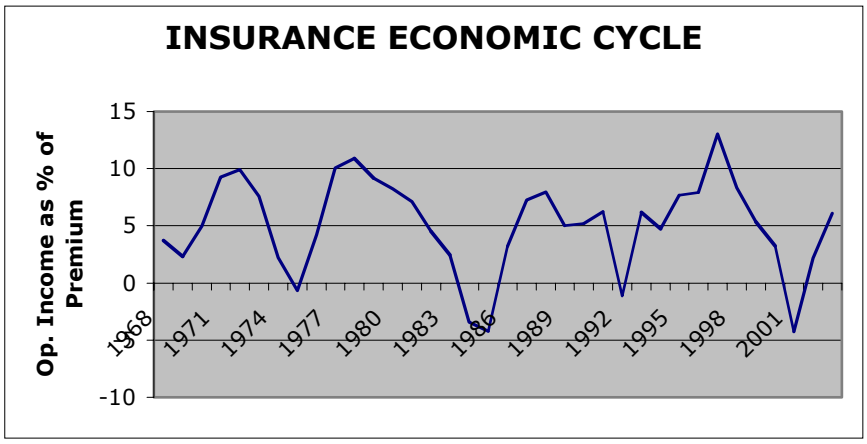
THE GOOD NEWS – STEEP MEDICAL MALPRACTICE RATE HIKES ARE OVER

The insurance industry is a very cyclical business. Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely under price their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market that usually degenerates into a "liability insurance crisis."

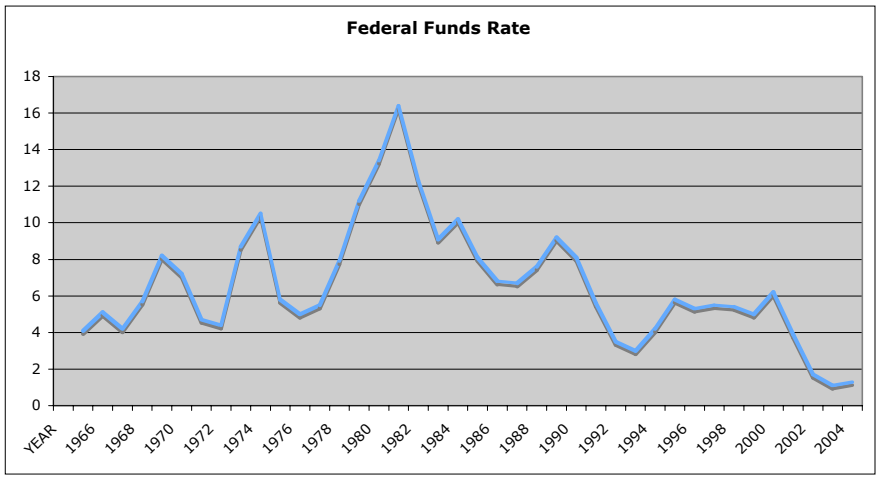
A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most lines of liability insurance were affected. Again, beginning in late 2000, the country started experiencing a "hard market," this time affecting property as well as liability coverage, with some lines of insurance seeing rate increases of 100 percent or more.

The following exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)



Prior to late 2000, the industry had been in a soft market since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to ten-year economic cycle. No matter how much they cut their rates, insurers wound up with a great profit year when investing the "float" on premiums in an amazing stock and bond market. (The "float" occurs during the time between when insurers receive premium payments and pay out insurance losses. There is about a 15-month lag in auto insurance and a five to ten year lag in medical malpractice.) Further, interest rates were relatively high through the 1990s as the Federal Reserve Board focused on recovery from the recession rather than inflation.

But in 2000, the market started to turn with a vengeance as the Federal Reserve cut interest rates again and again. For medical malpractice insurers, mainly investing in bonds, this sharply reduced future expectations for investment returns and was reflected in their ratemaking by raising rates.



This cut in interest rates began to take place before September 11th, as the chart above shows. The terrorist attacks sped up the price increases that were coming, collapsing two years of anticipated increases into a few months. The increases we witnessed were mostly due to the cycle turn, not the terrorist attack or any other single factor. This was a classic economic cycle bottom.

Fortunately, the hard market is over. Medical malpractice written premiums rose by only 4 percent in 2004[1], following three years of double digit increases. We anticipate at least eight years of small medical malpractice price increases until the next economic cycle turns hard.

MEDICAL MALPRACTICE WRITTEN PREMIUMS AND PAID LOSSES

I have tested two hypotheses advanced by the insurance industry to justify sharp premium increases in recent years. First, if large jury verdicts in medical malpractice cases or any other tort system costs are having a significant impact on the overall costs for insurers and are therefore the reason behind skyrocketing insurance rates, then losses per doctor should be rising faster than medical inflation over time. Second, if lawsuits or other tort costs are the cause of rate increases for doctors -- rather than decreasing interest rates and other economic factors -- those losses should be reflected in rate increases in line with such losses, not in ups and downs that instead reflect the state of the economy, the well-documented insurance economic cycle, interest rates, the stock market or the profitability of insurers' investment income.

The data show that both hypotheses are completely false, as demonstrated in the charts below. First, these charts show that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985, and flat

[1] Review and Preview, A.M. Best and Co., January 2005, Page 19.

since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years from 2001 through 2003 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2003. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

While payouts closely track medical inflation, medical malpractice premiums diverge significantly. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have fluctuated almost precisely with the insurers' economic cycle, which is driven by such factors as investment income, poor insurer business decisions and changing interest rates, not by lawsuits, jury awards, the tort system or other causes. Moreover, medical malpractice insurance premiums rose much faster in 2002 and 2003 than was justified by insurance payouts. This hike is similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

In sum, the results of my analysis are startling; premiums rise and fall with the insurance industry's economic cycle, but paid losses do not[2]:

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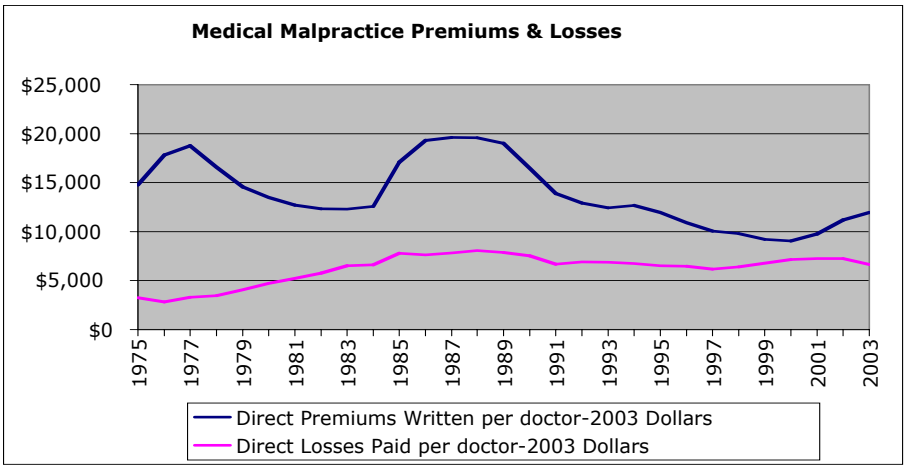
[2] **Sources:** A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available (premiums and losses); American Medical Assoc. (number of non-federal doctors, 1975, 1980, 1985, 1986, 1990, 1992-2002; other years estimated); Bureau of Labor Statistics (CPI).4 See Exhibit 3 for underlying data. **"Direct Premiums Written"** is the amount of money that insurers collected in premiums from doctors during that year. **"Direct Losses Paid"** is what insurers actually paid out that year to people who were injured – all claims, jury awards and settlements – plus what insurance companies pay their own lawyers to fight claims.
We calculate the paid losses on a per doctor basis to remove from the trend we are studying the effect of the ever increasing number of doctors in America. We acknowledge that the number of doctors includes a certain number of doctors that are retired or otherwise not in the medical malpractice system, but since we are interested in overall loss trends over time, and since the percentage of doctors in that category should not vary much year to year, this fact should not significantly impact our results. "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.,* insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal,* June 24, 2002.



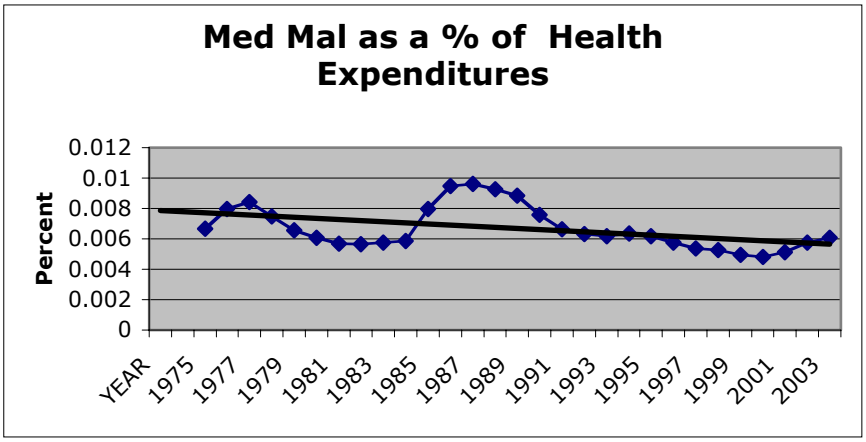
The calculations underlying this chart are attached as Appendix A.

MEDICAL MALPRACTICE HAS LIMITED IMPACT ON HEALTH CARE COST

In last decade, paid malpractice claims totaled $37.8 billion; 1.3 million claims were closed. Thus the average payment per closed claim was $27,524, from which both the plaintiff and defense attorneys were compensated.

Of the 1.3 million claims, only 352,000 received any payment. This means that only 23 percent of claimants got any money. If you were one of the "lucky" ones whose injury was severe enough and the negligence clear enough to qualify you for a payment, your payment averaged $107,000, from which your lawyers were paid. On average, about 35,000 claims per year are paid out in any way.

The relatively low overall cost of this system is shown in the following chart:



Currently, the total premiums paid by doctors and hospitals total $10.1 billion[3], compared to the Health Expenditures of $1,674 billion,[4] which means that medical malpractice premiums represent six-tenths of one percent of Health Expenditures in the nation. Note that the line of best fit shows that this tiny percentage is declining over time.

So, even if Congress took a step we would never advise and completely immunized doctors and hospitals from legal liability in the event of medical negligence, total health care costs in this country would hardly be affected.

WHAT SHOULD CONGRESS DO?

First, Congress should do no harm. The national problem of serious rate hikes is over for the time being, except perhaps in a couple of states. This gives Congress time to carefully study the situation and not rush to take action that would harm victims of medical negligence.

Unfortunately, medical malpractice legislation passed in 2003 by the House of Representatives, H.R. 5, would do harm to consumers of healthcare and to victims of medical malpractice. The cumulative effect of capping non-economic and punitive damages, shielding liability for some drug manufacturers, and changing joint and several liability and collateral source rules would be to remove key deterrents to dangerous medical practices. Moreover, H.R. 5 does absolutely nothing to deter physician negligence.

Part of a Congressional evaluation of medical malpractice should look at the question of why so few people hurt by medical negligence are recovering compensation for that negligence. Perhaps a review of no-fault and other mechanisms for compensating victims of medical negligence might be considered. How much would alternative systems cost? How can the system be made more efficient while fully protecting the many victims of malpractice in the nation?

Another aspect of this study should be insurance reform, which is a way for the regulators to control the harmful excesses of a business cycle that causes sudden and unjustifiable price spikes and coverage cutbacks every decade or so. We recommend looking at the system passed in California, the Proposition 103 system, which has worked wonders to hold down rates in that state.[5] For example, this system has allowed consumer representatives to successfully intervene in opposition to recently proposed rate hikes by some malpractice insurers, which has led to much lower rates for doctors. Congress should consider creating a national reinsurance facility, which would serve to stabilize the wild swings in rates that characterize the current insurance cycle. A national reinsurance facility would also make insurance more readily available by spreading the cost of large medical injuries to a national base, which does not presently occur.

Congress should also evaluate methods for reducing negligence and medical errors by physicians and medical facilities. It is well known that a very small proportion of doctors cause a very high percentage of the claims for medical malpractice. Yet many states have weak

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[3] A.M. Best and Co., special report, run for the Americans for Insurance Reform.

[4] Statistical Abstract of the United States, 2005 Edition, U.S. Census Bureau, 2003 is the Bureau's projection.

[5] See "Why Not the Best," a report on how Proposition 103 works at www.consumerfed.org.

procedures for disciplining dangerous doctors and stopping them from continuing to practice, putting American consumers of health care at risk.

The 1999 report regarding medical errors by the Institute on Medicine (IOM) demonstrates that far too many Americans face the serious possibility of an injury, or even death, due to medical mistakes in the hospital. Using the IOM's low estimate of 44,000 deaths per year, medical errors are the eighth leading cause of death in this country, ahead of breast cancer and AIDS. The IOM's high-range estimate of 98,000 deaths a year would make medical errors the fifth leading cause of death, more than all accidental deaths.[6] Of course, some medical errors are directly attributable to physician negligence and some are not, but the IOM report clearly demonstrates the serious implications of rolling back the legal rights of Americans who have been harmed or killed by malpractice. If Congress gets it wrong, the pain and suffering incurred by many families across the country will only increase.

Before this Committee rushes through tort reform legislation, I urge you to get the facts. As the evidence I've presented you with today shows: (a) insurers have themselves to blame for the predicament they—and physicians and patients throughout the country—face, and (b) you have plenty of time to make sure that any action you take does no harm, given the return of the soft insurance market and very small price increases for doctors.

[6] *To Err is Human, Building a Safer Health System,* Institute of Medicine, National Academy of Sciences; November, 1999.

APPENDIX A

Year	Written Premiums (thousands)	Paid Losses (thousands)	Loss Ratio	Number of Doctors (Non-federal)	Medical Care Inflation (CPI-U)	Direct Premiums Written per Doctor	Direct Losses Paid per Doctor	Direct Premiums Written per Doctor-2003 Dollars	Direct Losses Paid per Doctor-2003 Dollars
1975	$865,208	$190,867	0.221	366,425	47.5	$2,361.21	$520.89	$14,793.63	$3,263.51
1976	$1,187,978	$188,545	0.159	381,000	52	$3,118.05	$494.87	$17,844.85	$2,832.17
1977	$1,423,091	$248,969	0.175	395,575	57	$3,597.53	$629.39	$18,782.87	$3,286.05
1978	$1,412,555	$294,456	0.208	410,151	61.8	$3,443.99	$717.92	$16,584.64	$3,457.17
1979	$1,405,991	$391,800	0.279	424,726	67.5	$3,310.35	$922.48	$14,594.96	$4,067.10
1980	$1,493,543	$521,849	0.349	439,301	74.9	$3,399.82	$1,187.91	$13,508.49	$4,719.91
1981	$1,616,470	$665,570	0.412	455,904	82.9	$3,545.64	$1,459.89	$12,728.37	$5,240.81
1982	$1,815,056	$847,543	0.467	472,507	92.5	$3,841.33	$1,793.72	$12,358.71	$5,770.92
1983	$2,033,911	$1,079,862	0.531	489,109	100.6	$4,158.40	$2,207.81	$12,301.59	$6,531.27
1984	$2,282,590	$1,197,979	0.525	505,712	106.8	$4,513.62	$2,368.90	$12,577.27	$6,600.97
1985	$3,407,177	$1,556,300	0.457	522,315	113.5	$6,523.22	$2,979.62	$17,104.06	$7,812.64
1986	$4,335,863	$1,709,883	0.394	547,222	122	$7,923.41	$3,124.66	$19,327.92	$7,622.12
1987	$4,781,084	$1,905,491	0.399	556,647	130.1	$8,589.08	$3,423.16	$19,647.27	$7,830.38
1988	$5,166,811	$2,128,281	0.412	566,072	138.6	$9,127.48	$3,759.74	$19,598.40	$8,072.85
1989	$5,500,540	$2,273,628	0.413	575,496	149.3	$9,557.91	$3,950.73	$19,051.81	$7,874.99
1990	$5,273,360	$2,415,117	0.458	584,921	162.8	$9,015.51	$4,128.96	$16,480.44	$7,547.78
1991	$5,043,773	$2,423,418	0.480	609,384	177	$8,276.84	$3,976.83	$13,916.31	$6,686.47
1992	$5,228,362	$2,808,838	0.537	633,846	190.1	$8,248.63	$4,431.42	$12,913.17	$6,937.35
1993	$5,469,575	$3,028,086	0.554	648,662	201.4	$8,432.09	$4,668.20	$12,459.73	$6,898.00
1994	$5,948,361	$3,174,987	0.534	661,960	211	$8,985.98	$4,796.34	$12,674.07	$6,764.89
1995	$6,107,568	$3,326,846	0.545	689,121	220.5	$8,862.84	$4,827.67	$11,961.82	$6,515.71
1996	$6,002,233	$3,556,151	0.592	717,335	228.2	$8,367.41	$4,957.45	$10,912.09	$6,465.10
1997	$5,864,218	$3,587,566	0.612	737,263	234.6	$7,954.04	$4,866.06	$10,090.03	$6,172.80
1998	$6,040,051	$3,957,619	0.655	757,865	242.1	$7,969.82	$5,222.06	$9,796.86	$6,419.19
1999	$6,053,323	$4,446,975	0.735	778,491	250.6	$7,775.71	$5,712.30	$9,234.05	$6,783.64
2000	$6,303,206	$4,988,474	0.791	793,211	260.8	$7,946.44	$6,288.96	$9,067.72	$7,176.36
2001	$7,288,933	$5,424,197	0.744	814,776	272.8	$8,945.93	$6,657.29	$9,759.20	$7,262.49
2002	$8,928,252	$5,806,463	0.650	831,645	285.6	$10,735.65	$6,981.90	$11,186.73	$7,275.26
2003	$10,142,575	$5,622,377	0.554	848,514	297.1	$11,953.34	$6,626.15	$11,973.46	$6,637.30

Sources: A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available (premiums and losses); American Medical Assoc. (number of non-federal doctors, 1975, 1980, 1985, 1986, 1990, 1992-2002; other years estimated); Bureau of Labor Statistics (CPI).